NATIONAL HEALTHCARE CORP
Form 10-K
February 20, 2015

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)
[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES AND EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2014

OR
[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File No. 001-13489

(Exact name of registrant as specified in its Corporate Charter)

Delaware	**52-2057472**
(State of Incorporation)	(I.R.S. Employer I.D. No.)

100 Vine Street
Murfreesboro, Tennessee 37130
(Address of principal executive offices)
Telephone Number: **615-890-2020**

Securities registered pursuant to Section 12(b) of the Act.

Title of Each Class	Name of Each Exchange on which Registered
Shares of Common Stock	**NYSE MKT**
Shares of Preferred Cumulative Convertible Stock	**NYSE MKT**

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes [ ] No [x]

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes [ ] No [x]

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days: Yes [x] No [ ]

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such period that the registrant was required to submit and post such files).

Yes [x] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [ ]

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Rule 12b-2 of the Act). Large accelerated filer [ ] Accelerated filer [x] Non-accelerated filer [ ] Smaller reporting company [ ]

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes [ ] No [x]

The aggregate market value of Common Stock held by non-affiliates on June 30, 2014 (based on the closing price of such shares on the NYSE MKT) was approximately $435 million. For purposes of the foregoing calculation only, all directors, named executive officers and persons known to the Registrant to be holders of 5% or more of the Registrant s Common Stock have been deemed affiliates of the Registrant.

The number of shares of Common Stock outstanding as of February 12, 2015 was 14,110,859.

Documents Incorporated by Reference

The following documents are incorporated by reference into Part III, Items 10, 11, 12, 13 and 14 of this Form 10-K: The Registrant s definitive proxy statement for its 2015 shareholder s meeting.

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PART 1

ITEM 1.

BUSINESS

General Development of Business

National HealthCare Corporation, which we also refer to as NHC or the Company, began business in 1971. Our principal business is the operation of skilled nursing facilities with associated assisted living and independent living centers. Our business activities include providing sub-acute and post-acute skilled nursing care, intermediate nursing care, rehabilitative care, senior living services, and home health care services. We have a non-controlling ownership interest in a hospice care business that services NHC owned health care centers and others. In addition, we provide management services, accounting and financial services, and insurance services to third party owners of health care facilities. We also own the real estate of thirteen healthcare properties and lease these properties to third party operators. We operate in 10 states, and our owned and leased properties are located primarily in the southeastern United States.

Narrative Description of the Business

At December 31, 2014, we operate or manage 74 skilled nursing facilities with a total of 9,462 licensed beds. These numbers include 66 centers with 8,551 beds that we lease or own and eight centers with 911 beds that we manage for others. Of the 66 leased or owned facilities, 35 are leased from National Health Investors, Inc. ("NHI").

Our 18 assisted living centers (16 leased or owned and two are managed) have 815 units (708 units leased or owned and 107 units managed).

Our five independent living centers (four leased or owned and one managed) have 475 retirement apartments (338 apartments leased or owned, and 137 apartments managed).

We operate 36 homecare programs licensed in four states (Tennessee, South Carolina, Missouri and Florida) and provided 477,323 homecare patient visits to 19,222 patients in 2014.

We have a partnership agreement and a 75.1% non-controlling ownership interest in Caris Healthcare, LP (Caris), a business that specializes in hospice care services in NHC owned health care centers and in other settings. Caris provides hospice care to over 1,000 patients per day in 25 locations in Missouri, South Carolina, Tennessee, and Virginia.

We operate specialized care units within certain of our healthcare centers such as Alzheimer's disease care units, sub-acute nursing units and a number of in-house pharmacies. Similar specialty units are under consideration at a number of our centers, as well as free standing projects.

Net Patient Revenues. Health care services we provide include a comprehensive range of services. In fiscal 2014, 95.1% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2014 were as follows:

A.

Skilled Nursing Facilities. The most significant portion of our business and the base for our other health care services is the operation of our skilled nursing facilities. In our facilities, experienced medical professionals provide medical services prescribed by physicians. Registered nurses, licensed practical nurses and certified nursing assistants provide comprehensive, individualized nursing care 24 hours a day. In addition, our facilities provide licensed therapy services, quality nutrition services, social services, activities, and housekeeping and laundry services. We operate 74 skilled nursing facilities as of December 31, 2014. We manage eight facilities for third party owners. Revenues from the 66 facilities we own or lease are reported as net patient revenues in our financial statements. Management fee income is recorded as other revenues from the eight facilities that we manage. We generally charge 6% to 7% of facility net operating revenues for our management services. Average occupancy in skilled nursing facilities we operate was 88.9% during the year ended December 31, 2014.

B.

Rehabilitative Services. We provide therapy services through Professional Health Services, a subsidiary of NHC. Our licensed therapists provide physical, speech, respiratory and occupational therapy for patients recovering from strokes, heart attacks, orthopedic conditions, neurological illnesses, or other illnesses, injuries or disabilities. We maintained a rehabilitation staff of over 1,600 highly trained, professional therapists in 2014. The majority of our rehabilitative services are for patients in our owned and managed skilled nursing facilities. However, we also provide services to over 80 additional health care providers. Our rates for these services are competitive with other market rates.

C.

Medical Specialty Units. All of our long-term care facilities participate in the Medicare program, and we have expanded our range of offerings by the creation of center-specific medical specialty units such as our Alzheimer's disease care units and subacute nursing units. Our trained staff provides care for Alzheimer s patients in early, middle and advanced stages of the disease. We provide specialized care and programs for persons with Alzheimer s or related disorders in dedicated units within many of our skilled nursing facilities. Our specialized rehabilitation programs are designed to shorten or eliminate hospital stays and help to reduce the cost of quality health care. We develop individualized patient care plans to target appropriate medical and functional planning objectives with a primary goal where feasible for a return to home or a similar environment.

D.

Managed Care Contracts. We contract with over 60 managed care organizations (MCO's) and insurance carriers for the provision of subacute and other medical specialty services by our owned and managed facilities. Managed care patient days were 242,621 in 2014; 181,152 in 2013; and 156,827 in 2012.

E.

Assisted Living Centers. Our assisted living centers are dedicated to providing personal care services and assistance with general activities of daily living such as dressing, bathing, meal preparation and medication management. We perform resident assessments to determine what services are desired or required and our qualified staff encourages residents to participate in a range of activities. We own or lease 16 and manage two assisted living facilities. Of these 18 centers, seven are located within the physical structure of a skilled nursing facility or retirement center and eleven are freestanding. In 2014, the rate of occupancy was 89.6%. Certificates of Need are not required to build these projects and we believe that overbuilding has occurred in some of our markets.

F.

Independent Living Centers. Our four owned or leased and one managed independent living centers offer specially designed residential units for the active and ambulatory elderly and provide various ancillary services for our residents, including restaurants, activity rooms and social areas. Charges for services are paid from private sources without assistance from governmental programs. Independent living centers may be licensed and regulated in some

states, but do not require the issuance of a Certificate of Need ("CON") such as is required for skilled nursing facilities. We have, in several cases, developed independent living centers adjacent to our nursing facilities with an initial construction of 40 to 80 units and which units are rented by the month; thus these centers offer an expansion of our continuum of care. We believe these independent living units offer a positive marketing aspect of our skilled nursing facilities.

We have one owned retirement center which is a "continuing care community", where the resident pays a substantial entrance fee and a monthly maintenance fee. The resident then receives a full range of services, including home health nursing, without additional charge.

G.

Homecare Programs. Our home health care programs (we call them homecares) assist those who wish to stay at home or in assisted living residences but still require some degree of medical care or assistance with daily activities. Registered and licensed practical nurses and therapy professionals provide skilled services such as infusion therapy, wound care and physical, occupational and speech therapies. Home health aides may assist with daily activities such as assistance with walking and getting in and out of bed, personal hygiene, medication assistance, light housekeeping and maintaining a safe environment. NHC operates 36 homecare licensed and Medicare-certified offices in four states (Tennessee, South Carolina, Missouri and Florida) and some of our homecare patients are previously discharged from our skilled nursing facilities. Medicare reimbursement for homecare services is paid under a prospective payment system. Under this payment system, we receive a prospectively determined amount per patient per 60 day episode as defined by Medicare guidelines. Medicare episodes increased from 20,947 in 2013 to

21,736 in 2014. Patients served increased from 18,995 in 2013 to 19,222 in 2014. Visits increased from 469,437 in 2013 to 477,323 in 2014.

H.

Pharmacy Operations. At December 31, 2014, we operated four regional pharmacy operations (one in east Tennessee, one in central Tennessee, one in South Carolina, and one in Missouri). These pharmacy operations use a central location to supply pharmaceutical services (consulting and medications) and supplies. Regional pharmacies bill Medicare Part D Prescription Drug Plans (PDPs) electronically and directly for inpatients who have selected a PDP. Our regional pharmacies currently serve 53 owned facilities, five managed facilities, and 13 third party entities.

Other Revenues. We generate revenues from management, accounting and financial services to third party owners of healthcare facilities, from insurance services to our managed healthcare facilities, and from rental income. In fiscal 2014, 4.9% of our net operating revenues were derived from such other sources. The significant sources of our other revenues are described as follows:

A.

Management, Accounting and Financial Services. We provide management services to skilled nursing facilities, assisted living centers and independent living centers operated by third party owners. We typically charge 6% to 7% of the managed centers net operating revenues as a fee for these services. Additionally, we provide accounting and financial services to other skilled nursing facilities or related types of entities for small operators. No management services are provided for entities in which we provide accounting and financial services. As of December 31, 2014, we perform management services for 11 healthcare facilities and accounting and financial services for 20 healthcare facilities.

B.

Insurance Services. NHC owns a Tennessee domestic licensed insurance company. The company is licensed in several states and provides workers compensation coverage to the majority of NHC operated and managed facilities in addition to other skilled nursing facilities, assisted living and retirement centers. A second wholly owned insurance subsidiary is licensed in the Cayman Islands and provides general and professional liability coverage in substantially all of NHC s owned and managed centers. This company elects to be taxed as a domestic subsidiary. We also self-insure our employees (referred to as "partners") health insurance benefit program at a cost we believe is less than a commercially obtained policy. Finally, we operate a long-term care insurance division, which is licensed to sell commercially underwritten long-term care policies.

C.

Rental Income. The healthcare properties currently owned and leased to third party operators include nine skilled nursing facilities and four assisted living communities.

Non-Operating Income. We generate non-operating income from equity in earnings of unconsolidated investments, from dividends and realized gains and losses on marketable securities, interest income, and other miscellaneous non-operating income. The significant source of non-operating income is described as follows:

Equity in Earnings of Unconsolidated Investments. Earnings from investments in entities in which we lack control but have the ability to exercise significant influence over operating and financial policies are accounted for on the equity method. Our most significant equity method investment is a 75.1% non-controlling ownership interest in Caris Healthcare, L.P. ("Caris"), a business that specializes in hospice care services in NHC owned health care centers and in other settings. Caris currently has twenty-five locations serving four states (Missouri, South Carolina, Tennessee, and Virginia).

Development and Growth

We are undertaking to expand our post-acute and senior health care operations while protecting our existing operations and markets. The following table lists our recent construction and purchase activities.

Type of Operation	Description	Size	Location	Placed in Service
SNF	Acquisition	106 beds	Columbia, TN	September, 2013
SNF	Acquisition	92 beds	Columbia, TN	September, 2013
SNF	Acquisition	139 beds	Knoxville, TN	September, 2013
SNF	Acquisition	107 beds	Springfield, TN	September, 2013
SNF	Acquisition	94 beds	Madisonville, KY	September, 2013
SNF	Acquisition	112 beds	Rossville, GA	September, 2013
SNF	Leased	120 beds	Greenfield, MA	September, 2013
SNF	Leased	102 beds	Holyoke, MA	September, 2013
SNF	Leased	71 beds	Quincy, MA	September, 2013
SNF	Leased	100 beds	Taunton, MA	September, 2013
SNF	Leased	108 beds	Epsom, NH	September, 2013
SNF	Leased	114 beds	Manchester, NH	September, 2013
SNF	Leased	126 beds	Manchester, NH	September, 2013
SNF	New Facility	90 beds	Tullahoma, TN	October, 2013
SNF	Addition	50 beds	Lexington, SC	December, 2013
SNF/AL	Leased	120 beds / 52 units	Independence, MO	March, 2014
SNF	Leased	70 beds	Independence, MO	March, 2014
SNF/AL	Leased	130 beds / 52 units	St. Peters, MO	March, 2014
AL	Partnership	83 units	Augusta, GA	June, 2014
Psychiatric Hospital	Partnership	14 beds	Osage Beach, MO	June, 2014
SNF	New Facility	52 beds	Kingsport, TN	December 2014
SNF/AL	New Facility	92 beds/60 Units	Sumner County, TN	Under construction

Memory Care	Partnership	60 beds	St. Peters, MO	Under construction
SNF/AL	New Facility	90 beds / 80 Units	Nashville, TN	Under construction

For the development projects under construction at December 31, 2014, we anticipate the 92-bed skilled nursing facility and 60-unit assisted living facility located in Sumner County, Tennessee to begin operations during the first quarter of 2015; the 60-bed memory care facility located in St. Peters, Missouri to begin operations during the fourth quarter of 2015 (we have a 25% ownership interest in this partnership), and the 90-bed skilled nursing facility and 80-unit assisted living facility located in Nashville, Tennessee to begin operations in the second or third quarter of 2016.

Construction on both an 80-unit assisted living community in Garden City, South Carolina and a 76-unit assisted living community in Bluffton, South Carolina are scheduled to begin in the first quarter of 2015.

During the second quarter of 2015, we anticipate beginning construction on a replacement center (SNF) that will combine the 92 beds of NHC Hillview in Columbia, Tennessee with 20 beds from the existing skilled nursing unit at Maury Regional Medical Center. The resulting replacement center will be a partnership between NHC and Maury Regional Medical Center.

During 2015, we plan to apply for Certificates of Need for additional beds in certain of our markets. We also will evaluate the feasibility of expansion into new markets by building private pay health care centers or assisted living communities.

Skilled Nursing Facilities

The skilled nursing facilities operated by our subsidiaries provide in-patient skilled and intermediate nursing care services and in-patient and out-patient rehabilitation services. Skilled nursing care consists of 24-hour nursing service by registered or licensed practical nurses and related medical services prescribed by the patient's physician. Intermediate nursing care consists of similar services on a less intensive basis principally provided by non-licensed personnel. These distinctions are generally found in the health care industry although for Medicaid reimbursement purposes, some states in which we operate have additional classifications, while in other states the Medicaid rate is the same regardless of patient classification. Rehabilitative services consist of physical, speech, and occupational therapies, which are designed to aid the patient's recovery and enable the patient to resume normal activities.

Each health care facility has a licensed administrator responsible for supervising daily activities, and larger facilities have assistant administrators. All have medical directors, a director of nurses and full-time registered nurse coverage. All centers provide physical therapy and most have other rehabilitative programs, such as occupational or speech therapy. Each facility is located near at least one hospital and is qualified to accept patients discharged from such hospitals. Each facility has a full dining room, kitchen, treatment and examining room, emergency lighting system,

and sprinkler system where required. Management believes that all facilities are in compliance with the existing fire and life safety codes.

We provide centralized management and support services to NHC operated healthcare facilities. The management and support services include operational support through the use of regional vice presidents and regional nurses, accounting and financial services, cash management, data processing, legal, consulting and services in the area of rehabilitative care. Our personnel are employed by our administrative services affiliate, National Health Corporation ("National"), which is also responsible for overall services in the area of personnel, loss control, insurance, education and training. We reimburse the administrative services contractor by paying all the costs of personnel employed for our benefit as well as a fee. National is wholly owned by the National Health Corporation Employee Stock Ownership Plan and provides its services only to us.

We provide management services to centers operated under management contracts and offsite accounting and financial services to other third party owners, all pursuant to separate contracts. The term of each contract and the amount of the management fee or accounting and financial services fee is determined on a case-by-case basis. Typically, we charge 6% to 7% of net operating revenues of the managed centers for our management contracts and specific item fees for our accounting and financial service agreements. The initial terms of the contracts range from two years to ten years. In certain contracts, we maintain a right of first refusal should the owner desire to sell a managed center.

Skilled Nursing Facility Occupancy Rates

The following table shows certain information relating to occupancy rates for our owned and leased skilled nursing facilities:

	Year Ended December 31,		
	2014	2013	2012
Overall census	88.9%	89.2%	90.1%

Occupancy rates are calculated by dividing the total number of days of patient care provided by the number of patient days available (which is determined by multiplying the number of licensed beds by 365 or 366).

Customers and Sources of Revenues

No individual customer, or related group of customers, accounts for a significant portion of our revenues. We do not expect the loss of a single customer or group of related customers would have a material adverse effect.

Certain groups of patients receive funds to pay the cost of their care from a common source. The following table sets forth sources of net patient revenues for the periods indicated:

	Year Ended December 31,		
Source	2014	2013	2012
Medicare	39%	40%	42%
Medicaid	26%	25%	25%
Private Pay and Other	24%	25%	24%
Managed Care	11%	10%	9%

Total	100%	100%	100%

The source and amount of the revenues are further dependent upon (i) the licensed bed capacity of our health care facilities, (ii) the occupancy rate of the facilities, (iii) the extent to which the rehabilitative and other skilled ancillary services provided at each facility are utilized by the patients in the centers, (iv) the mix of private pay, Medicare and Medicaid patients, and (v) the rates paid by private paying patients and by the Medicare and Medicaid programs.

We attempt to attract an increased percentage of private and Medicare patients by providing rehabilitative services and increasing the marketing of those services through market areas and "Managed Care Offices", of which five were open at December 31, 2014. These services are designed to speed the patient's recovery and allow the patient to return home as soon as it is practical.

Medicare is a health insurance program for the aged and certain other chronically disabled individuals operated by the federal government. Medicare covers nursing home services for beneficiaries who require nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. For each eligible day a Medicare beneficiary is in a skilled nursing facility, Medicare pays the facility a daily payment, subject to adjustment for certain factors such as wage index in the particular geographic area. The payment covers all services provided by the skilled nursing facility for the beneficiary that day, including room and board, nursing, therapy and drugs, as well as an estimate of capital-related costs to deliver those services.

Medicaid is a medical assistance program for the indigent, operated by individual states with the financial participation of the federal government. The states in which we operate currently use prospective cost-based reimbursement systems. Under cost-based reimbursement systems, the skilled nursing facility is reimbursed for the reasonable direct and indirect allowable costs it incurred in a base year in providing routine resident care services as defined by the program.

Private pay, managed care, and other sources include commercial insurance, individual patient funds, managed care plans and the Veterans Administration. Although payment rates vary among these sources, market forces and costs largely determine these rates. Private paying patients, private insurance carriers and the Veterans Administration generally pay on the basis of the center's charges or specifically negotiated contracts.

Government reimbursement programs such as Medicare and Medicaid prescribe, by law, the billing methods and amounts that health care providers may charge and be reimbursed to care for patients covered by these programs. Congress continually passes laws that effect major or minor changes in the Medicare and Medicaid programs.

Regulation and Licenses

Health care is an area of extensive regulatory oversight and frequent regulatory change. The federal government and the states in which we operate regulate various aspects of our business. These regulatory bodies, among other things, require us annually to license our skilled nursing facilities, assisted living facilities in some states and other health care businesses, including home health. In particular, to operate nursing facilities and provide health care services we must comply with federal, state and local laws relating to the delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate-setting, building codes and environmental protection.

Governmental and other authorities periodically inspect our skilled nursing facilities and home health agencies to assure that we continue to comply with their various standards. We must pass these inspections to continue our licensing under state law, to obtain certification under the Medicare and Medicaid programs, and to continue our participation in the Veterans Administration program. We can only participate in other third-party programs if our facilities pass these inspections. In addition, these authorities inspect our record keeping and inventory control.

From time to time, we, like others in the health care industry, may receive notices from federal and state regulatory agencies alleging that we failed to comply with applicable standards. These notices may require us to take corrective action, and may impose civil money penalties and/or other operating restrictions. If our skilled nursing facilities and home health agencies fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, we could lose our certification as a Medicare and Medicaid provider and/or lose our licenses.

Local and state health and social service agencies and other regulatory authorities specific to their location regulate, to varying degrees, our assisted living facilities. Although regulations and licensing requirements vary significantly from state to state, they typically address, among other things, personnel education, training and records; facility services, including administration of medication, assistance with supervision of medication management and limited nursing services; physical plant specifications; furnishing of resident units; food and housekeeping services; emergency

evacuation plans; and resident rights and responsibilities. If assisted living facilities fail to comply with licensing requirements, these facilities could lose their licenses. Most states also subject assisted living facilities to state or local building codes, fire codes and food service licensure or certification requirements. In addition, the manner and extent to which the assisted living industry is regulated at federal and state levels are evolving.

Changes in the laws or new interpretations of existing laws as applied to the skilled nursing facilities, the assisted living facilities or other components of our health care businesses, may have a significant impact on our operations.

In all states in which we operate, before a skilled nursing facility can make a capital expenditure exceeding certain specified amounts or construct any new skilled health care beds, approval of the state health care regulatory agency or agencies must be obtained and a Certificate of Need issued. The appropriate state health planning agency must review the Certificate of Need according to state specific guidelines before a Certificate of Need can be issued. A Certificate of Need is generally issued for a specific maximum amount of expenditure and the project must be completed within a specific time period. There is no advance assurance that we will be able to obtain a Certificate of Need in any particular instance. In some states, approval is also necessary in order to purchase existing health care beds, although the purchaser is normally permitted to avoid a full scale Certificate of Need application procedure by giving advance written notice of the acquisition and giving written assurance to the state regulatory agency that the change of ownership will not result in a change in the number of beds, services offered and, in some cases, reimbursement rates at the facility.

While there are currently no significant legislative proposals to eliminate Certificates of Need pertaining to skilled nursing care in the states in which we do business, deregulation in the Certificate of Need area would likely result in increased competition and could adversely affect occupancy rates and the supply of licensed and certified personnel.

Medicare and Medicaid Participation

All health care centers, owned, leased or managed by us are certified to participate in Medicare. Health care centers participating in Medicare are known as SNFs ("Skilled Nursing Facilities"). All but six of our affiliated nursing centers participate in Medicaid. All of our homecares (Home health agencies) participate in Medicare, which comprises over 80% of their revenue. Homecares also participate in Medicaid.

During the fiscal years, we received payments from Medicare and, if participating, from Medicaid. We record as receivables the amounts we ultimately expect to receive under the Medicare and Medicaid programs and record into profit or loss any differences in amounts actually received at the time of interim or final settlements. Adjustments have not had a material adverse effect within the last three years.

Certifications and Participation Requirements; Efforts to Impose Reduced Payments

Changes in certification and participation requirements of the Medicare and Medicaid programs have restricted, and are likely to continue to restrict further, eligibility for reimbursement under those programs. Failure to obtain and maintain Medicare and Medicaid certification at our nursing centers would result in denial of Medicare and Medicaid payments which would likely result in a significant loss of revenue. In addition, private payors, including managed care payors, increasingly are demanding that providers accept discounted payments resulting in lost revenue for specific patients. Efforts to impose reduced payments, greater discounts and more stringent cost controls by government and other payors are expected to continue. For the fiscal year ended December 31, 2014, we derived 39% and 26% of our net patient revenues from the Medicare and Medicaid programs, respectively. Any reforms that significantly limit rates of reimbursement under the Medicare and Medicaid programs could have a material adverse effect on our profitability and cash flows. We are unable to predict what reform proposals or reimbursement limitations will be adopted in the future or the effect such changes will have on our operations. No assurance can be given that such reforms will not have a material adverse effect on us.

Medicare Legislation and Regulations

Federal Health Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA" or, commonly, ACA) and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), which represents significant changes to the current U.S. health care system (collectively the "Acts"). The primary goals of the Acts are to: (1) expand coverage to Americans without health insurance, (2) reform the delivery system to improve quality and drive efficiency, (3) and to lower the overall costs of providing health care. The timeline of the enacted provisions span over several years some of the provisions were effective immediately in 2010 and others will be phased in through 2020.

The U.S. Supreme Court has since issued its ruling on the constitutionality of a key provision in the ACA, which is the requirement that every American maintains a minimum level of health coverage or pays a penalty beginning in 2014. The Supreme Court upheld the constitutionality of the individual mandate , holding that the penalty for not doing so could reasonably be interpreted as a tax, which the Constitution permits. The ruling also permits the federal government to pursue a broad expansion of the Medicaid program, but the ruling gives the states the maximum flexibility on whether to do so. With Medicaid coverage expansion occurring in some states in 2014, the current Administration may release a host of regulations and an array of new taxes and fees. It is uncertain at this time the effect the Acts, their modifications, or Medicaid expansion will have on our future results of operations or cash flows.

Skilled Nursing Facilities (SNFs)

SNF PPS - Medicare is uniform nationwide and reimburses nursing centers under a fixed payment methodology named the Skilled Nursing Facility Prospective Payment System ("SNF PPS"). SNF PPS is an acuity based classification system that uses nursing and therapy indexes adjusted by geographical wage indexes to calculate per diem rates for each Medicare patient. Payment rates are updated annually and are generally increased or decreased each October when the federal fiscal year begins. The acuity classification system is named RUGs (Resource Utilization Groups IV). There are currently 66 classifications of RUG groups.

On April 1, 2013, the automatic 2% cuts (known as "sequestration") began for Medicare providers. The resulting decrease in revenue to our skilled nursing facilities was approximately $4,500,000 for the 2014 calendar year, or $1,125,000 per quarter. We are unable to predict the financial impact of other cuts Congress may implement. However, such impact may be adverse and material to our future results of operations and cash flows.

In July 2013, CMS released its skilled nursing facility PPS update for the fiscal year 2014, which began October 1, 2013. The notice provided for a 1.3% rate update, which reflects a 2.3% market basket increase less a 0.5% multifactor productivity adjustment and a 0.5% adjustment to correct market basket forecasting errors in fiscal year 2012. CMS estimated the update increased overall payments to skilled nursing facilities in fiscal year 2014 by $470 million compared to fiscal year 2013 levels.

In August 2014, CMS released its skilled nursing facility PPS update for the fiscal year 2015, which began October 1, 2014. The final rule provides for a 2.0% rate update, which reflects a 2.5% market basket increase less a 0.5% multifactor productivity adjustment as required by the ACA. CMS estimates the update will increase overall payments to skilled nursing facilities in fiscal year 2015 by $750 million compared to fiscal year 2014 levels. The 2015 final rule also includes wage index updates, revisions to the change of therapy (COT) other Medicare required assessment (OMRA) policy, and comments pertaining to CMS observations on therapy utilization trends. The effect of the 2015 PPS rate update on our revenues will be dependent upon our census and the mix of our patients at the PPS payment rates.

Homecares (HHAs)

HH PPS - Medicare is uniform nationwide and reimburses homecares under a fixed payment methodology named the Home Health Prospective Payment System ("HH PPS"). Generally, Medicare makes payments under the HH PPS on the basis of a national standardized 60-day episode payment, adjusted for case mix and geographical wage index. Payment rates are updated at the beginning of each calendar year. The acuity classification system is named HHRGs (Home Health Resource Groups).

On April 1, 2013, the automatic 2% Medicare cuts began for homecare providers. The resulting decrease in revenue to our homecare programs was approximately $1,200,000 for the 2014 calendar year, or $300,000 per quarter.

On November 22, 2013 and effective January 1, 2014, CMS issued the final rule for 2014 home health prospective payment system rates, which included (i) a market basket increase of 2.3 percent, (ii) rebasing of Medicare reimbursement rates, with annual reductions of 3.5 percent for each of the next four years beginning January 2014, (iii) changes in the Wage Index with no overall impact and (iv) rebasing all case mix weights to 1.0 from an average case mix weight of 1.3464 in 2013, as provided for under the Affordable Care Act. The rule also provided for changes in low utilization payments amounts and the removal of 170 diagnosis codes, among other changes. In total, CMS

predicted that home health agencies would experience an approximate 1.05 percent reduction in reimbursement for 2014.

On October 30, 2014 and effective January 1, 2015, CMS released its final rule for the 2015 home health prospective payment system. The final rule reduces home health payments overall by 0.3 percent from 2014 payment levels. The payment decrease reflects the impact of the 2.1% home health payment update ($390 million increase) and the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies conversion factor (2.4% or $450 million decrease). The final rule also makes adjustments to the new home health face-to-face requirements, updates the Home Health Quality Reporting Program, and discusses a potential value-based purchasing model to begin testing in 2016.

Medicaid Legislation and Regulations

Skilled Nursing Facilities (SNF)

State Medicaid plans subject to budget constraints are of particular concern to us. Changes in federal funding coupled with state budget problems and Medicaid expansion under the Affordable Care Act have produced an uncertain environment. States will more likely than not be unable to keep pace with nursing center inflation. States are under pressure to pursue other alternatives to long term care such as community and home-based services.

Effective July 1, 2013 and for the fiscal year 2014, the state of Tennessee implemented specific individual nursing facility rate increases. The resulting increase in revenue beginning July 1, 2013 and ending June 30, 2014 was approximately $1,800,000 annually, or $450,000 per quarter.

Effective July 1, 2014 and for the fiscal year 2015, the state of Tennessee implemented individual skilled nursing facility rate changes. With new state legislation being passed for the 2015 fiscal year, there are four components that impact Tennessee Medicaid reimbursement for skilled nursing facilities: a Level I or Level II per diem, a quarterly acuity payment, a quarterly Quality Improvement in Long-Term Services and Supports ("QuILTSS") payment (which are incentives based on qualifying criteria in several categories), and an assessment fee (expense). Effective July 1, 2014, each facility will now be charged an assessment fee based on 4.5% of net patient revenues. The assessment fee is replacing the former bed tax fee. In summary and for the 2015 fiscal year, we expect the Tennessee Medicaid reimbursement changes to increase income before income taxes by approximately $3,000,000 annually, or $750,000 per quarter.

Effective October 1, 2013 and for the fiscal year 2014, South Carolina implemented specific individual nursing facility rate increases. The resulting increase in revenue beginning October 1, 2013 was approximately $1,540,000 annually, or $385,000.

Effective October 1, 2014 and for the fiscal year 2015, South Carolina implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue beginning October 1, 2014 will be approximately $1,800,000 annually, or $450,000.

During the first quarter of 2014, the state of Missouri paid a retroactive rate increase back to July 1, 2013. In the first quarter of 2014, the Company recorded approximately $533,000 of additional net patient revenues for the July 1, 2013 through December 31, 2013 retroactive period. The resulting increase in revenue was approximately $250,000 per quarter for the 2014 year.

Competition

In most of the communities in which we operate health care centers, there are other health care centers with which we compete. We own, lease or manage (through subsidiaries) 74 skilled nursing facilities located in nine states. Each of these states are certificate of need states which generally requires the state to approve the opening of any new skilled nursing facilities. There are hundreds of operators of skilled nursing facilities in each of these states and no single operator, including us, dominates any of these state s skilled nursing care markets, except for some small rural markets which might have only one skilled nursing facility. In competing for patients and staff with these facilities, we depend upon referrals from acute care hospitals, physicians, residential care facilities, church groups and other community service organizations. The reputation in the community and the physical appearance of our facilities are important in obtaining patients, since members of the patient s family generally participate to a greater extent in selecting skilled nursing facilities than in selecting an acute care hospital. We believe that by providing and emphasizing rehabilitative

as well as skilled care services at our facilities, we are able to broaden our patient base and to differentiate our facilities from competing skilled nursing facilities.

As we expand into the assisted living market, we monitor proposed or existing competing assisted living centers. Our development goal is to link our skilled nursing facilities with our assisted living centers, thereby obtaining a competitive advantage for both.

Our homecares compete with other home health agencies (HHA s) in most communities we serve. Competition occurs for patients and employees. Our homecares depend on hospital and physician referrals and reputation in order to maintain a healthy census.

We experience competition in employing and retaining nurses, technicians, aides and other high quality professional and non-professional employees. In order to enhance our competitive position, we have an educational tuition loan program, an American Dietetic Association approved internship program, a specially designed nurse's aide training class, and we make financial scholarship aid available to physical therapy vocational programs. We support the Foundation for Geriatric Education. We also conduct an "Administrator in Training" course, 24 months in duration, for the professional training of administrators. Presently, we have five full-time individuals in this program. Four of our six regional vice presidents and 51 of our 74 health care center administrators are graduates of this program.

We experience competition in providing management and accounting services to other long-term health care providers. Those services are provided primarily to owners with whom we have had previous involvement

through ownership or leasing arrangements. Our insurance services are provided primarily to centers for which we also provide management and/or accounting services.

Our employee benefit package offers a tuition reimbursement program. The goal of the program is to insure a well-trained qualified work force to meet future demands. While the program is offered to all disciplines, special emphasis has been placed on supporting students in nursing and physical therapy programs. Students are reimbursed at the end of each semester after presenting tuition receipts and grades to management. The program has been successful in providing a means for many bright students to pursue a formal education.

Employees

As of December 31, 2014, our Administrative Services Contractor plus our managed centers had approximately 13,050 full and part time employees, who we call "Partners". No employees are represented by a bargaining unit. We believe our current relations with our employees are good.

Investor Information

We file reports with the Securities and Exchange Commission (SEC), including annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The public may read and copy any materials we file with the SEC at the SEC s Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer, and the SEC maintains an internet site at www.sec.gov that contains the reports, proxy and information statements, and other information we have filed electronically. We maintain an internet site at www.nhccare.com. We publish to this website our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and press releases. We do not necessarily have these filed the same day as they are filed with the SEC or released to the public, but rather have a policy of placing these on the web site within two (2) business days of public release or SEC filing.

We also maintain the following documents on the website:

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The NHC Code of Ethics. This Code has been adopted for all employees of our Administrative Services Contractor, officers and directors of the Company. The website will also disclose whether there have been any amendments or waivers to the Code of Ethics and Standards of conduct. To date there have been none.

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Information on our "NHC Valuesline", which allows our staff and investors unrestricted access to our Corporate Compliance Officer, executive officers and directors. The toll free number is 800-526-4064 and the communications may be incognito, if desired.

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The NHC Restated Audit Committee Charter.

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The NHC Compensation Committee Charter.

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The NHC Nomination and Corporate Governance Committee Charter

We will furnish, free of charge, a copy of any of the above documents to any interested investor upon receipt of a written request.

ITEM 1A.

RISK FACTORS

You should carefully consider the risk factors set forth below, as well as the other information contained in this Annual Report on Form 10-K. These risk factors should be considered in connection with evaluating the forward-looking statements contained in this Annual Report on Form 10-K, because these factors could cause the actual results and conditions to differ materially from those projected in forward-looking statements. The risks described below are not the only risks facing us. Additional risks and uncertainties that are not currently known to us or that we currently deem to be immaterial may also materially and adversely affect our business operations. Any of the following risks could materially adversely affect our business, financial condition or results of operations and cash flows.

Risks Relating to Our Company

We depend on reimbursement from Medicare, Medicaid and other third-party payors and reimbursement rates from such payors may be reduced. We derive a substantial portion of our revenue from third-party payors, including the Medicare and Medicaid programs. For the year ended December 31, 2014, we derived approximately 65% of our net patient revenues from the Medicare, Medicaid and other government programs. Third-party payor programs are highly regulated and are subject to frequent and substantial changes. Changes in the reimbursement rate or methods of payment from third-party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursements for our services has in the past, and could in the future, result in a substantial reduction in our revenues and operating margins. Additionally, net revenue realizable under third-party payor agreements can change after examination and retroactive adjustment by payors during the claims settlement processes or as a result of post-payment audits. Payors may disallow requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable because additional documentation is necessary or because certain services were not covered or were not reasonable and medically necessary. There also continue to be new legislative and regulatory proposals that could impose further limitations on government and private payments to health care providers. In some cases, states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and to make changes to private health care insurance. We cannot assure you that adequate reimbursement levels will continue to be available for the services provided by us, which are currently being reimbursed by Medicare, Medicaid or private third-party payors. Further limits on the scope of services reimbursed and on reimbursement rates could have a material adverse effect on our liquidity, financial condition and results of operations. It is possible that the effects of further refinements to PPS that result in lower payments to us or cuts in state Medicaid funding could have a material adverse effect on our results of operations. See Item 1, "Business Regulation and Licenses" and "Medicare Legislation and Regulations" and "Medicaid Legislation and Regulations".

We conduct business in a heavily regulated industry, and changes in, or violations of regulations may result in increased costs or sanctions that reduce our revenue and profitability. In the ordinary course of our business, we are regularly subject to inquiries, investigations and audits by federal and state agencies to determine whether we are in compliance with regulations governing the operation of, and reimbursement for, skilled nursing, assisted living and independent living facilities, hospice, home health agencies and our other operating areas. These regulations include those relating to licensure, conduct of operations, ownership of facilities, construction of new and additions to existing facilities, allowable costs, services and prices for services. In particular, various laws, including federal and state anti-kickback and anti-fraud statutes, prohibit certain business practices and relationships that might affect the provision and cost of health care services reimbursable under federal and/or state health care programs such as Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by federal governmental programs. Sanctions for violating the anti-kickback and anti-fraud statutes include criminal penalties and civil sanctions, including fines and possible exclusion from governmental programs such as Medicare and Medicaid.

In addition, the Stark Law broadly defines the scope of prohibited physician referrals under federal health care programs to providers with which they have ownership or other financial arrangements. Many states have adopted, or are considering, legislative proposals similar to these laws, some of which extend beyond federal health care programs, to prohibit the payment or receipt of remuneration for the referral of patients and physician referrals regardless of the source of the payment for the care. These laws and regulations are complex and limited judicial or regulatory interpretation exists. We cannot assure you that governmental officials charged with responsibility for enforcing the provisions of these laws and regulations will not assert that one or more of our arrangements are in

violation of the provisions of such laws and regulations.

The regulatory environment surrounding the post-acute and long-term care industry has intensified, particularly for larger for-profit, multi-facility providers like us. The federal government has imposed extensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies and other regulatory sanctions, including terminations from the Medicare and Medicaid programs, denials of payment for new Medicare and Medicaid admissions and civil monetary penalties. If we fail to comply, or are perceived as failing to comply, with the extensive laws and regulations applicable to our business, we could become ineligible to receive government program reimbursement, be required to refund amounts received from Medicare, Medicaid or private payors, suffer civil or criminal penalties, suffer damage to our reputation in various markets or be required to make significant changes to our operations. We are also subject to federal and state laws that govern financial and other arrangements between health care providers. These laws often prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers that are designed to induce the referral of patients to a particular provider for medical products and services. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in reimbursement programs and/or civil and criminal penalties. Furthermore, some states restrict certain business relationships between physicians and other

providers of health care services. Many states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. From time to time, we may seek guidance as to the interpretation of these laws; however, there can be no assurance that such laws will ultimately be interpreted in a manner consistent with our practices. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. Furthermore, should we lose licenses or certifications for a number of our facilities as a result of regulatory action or otherwise, we could be deemed in default under some of our agreements, including agreements governing outstanding indebtedness. We also are subject to potential lawsuits under a federal whistle-blower statute designed to combat fraud and abuse in the health care industry, known as the federal False Claims Act. These lawsuits can involve significant monetary awards to private plaintiffs who successfully bring these suits. When a private party brings a qui tam action under the False Claims Act, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. Even if, in the course of an investigation, the court partially unseals a complaint to allow the government and a defendant to work toward a resolution of the complaint's allegations, the defendant is prohibited from revealing to anyone the existence of the compliant or that the partial unsealing has occurred.

We have established policies and procedures that we believe are sufficient to ensure that our facilities will operate in substantial compliance with these anti-fraud and abuse requirements. While we believe that our business practices are consistent with Medicare and Medicaid criteria, those criteria are often vague and subject to change and interpretation. Aggressive anti-fraud actions, however, have had and could have an adverse effect on our financial position, results of operations and cash flows. See Item 1, "Business - Regulation and Licenses".

We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations, or the intensity of federal and state enforcement actions. Our failure to obtain or renew required regulatory approvals or licenses or to comply with applicable regulatory requirements, the suspension or revocation of our licenses or our disqualification from participation in certain federal and state reimbursement programs, or the imposition of other harsh enforcement sanctions could have a material adverse effect upon our operations and financial condition.

We are required to comply with laws governing the transmission and privacy of health information. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires us to comply with standards for the exchange of health information within our Company and with third parties, such as payors, business associates and patients. These include standards for common health care transactions, such as claims information, plan eligibility, payment information and the use of electronic signatures, unique identifiers for providers, employers, health plans and individuals, and security, privacy and enforcement. If we are found to be in violation of the privacy or security rules under HIPAA or other federal or state laws protecting the confidentiality of patient health information, we could be subject to criminal penalties and civil sanctions, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operations and liquidity.

We are defendants in significant legal actions, which are commonplace in our industry, and which could subject us to increased operating costs and substantial uninsured liabilities, which would materially and adversely affect our liquidity and financial condition. As is typical in the health ave the right to vote the relevant Common Shares and the relevant Common Shares are included in the beneficial ownership positions disclosed in this Schedule 13D.

In the past 60 days Armolink acquired 2,766,000 common shares from the third party in private transaction. As a result of the relationships and shareholdings described above, the Reporting Persons may be deemed to beneficially own Common Shares as of September 8, 2011 as follows:

Reporting Person	Number of Common Shares Beneficially Owned	Percentage of Common Shares
Mr. Zyuzin	280,669,025	67.42%
Calridge	280,463,641	67.38%
Bellasis	64,192,604	15.42%
Armolink	6,866,000	1.65%
MetHol	64,192,604	15.42%
Actiondeal	20,151,781	4.84%
Cyberwood	28,000,000	6,73%

(c) Not applicable.

(d) Not applicable.

(e) Not applicable.

Item 6. Contracts, Arrangements, Understanding or Relationships with Respect to Securities of the Issuer

None of the Reporting Persons or, to the best knowledge of the Reporting Persons, the other persons named in Item 2, is a party to any contract, arrangement, understanding or relationship (legal or otherwise) with respect to any securities of the Issuer, including but not limited to the transfer or voting of any securities of the Issuer, finder s fees, joint ventures, loan or option arrangements, puts or calls, guarantees of profits, division of profits or loss, or the giving or withholding of proxies, except the arrangements and relationships described in Item 5 above.

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Item 7. Material to be Filed as Exhibits

Exhibit No.	Description
1	Joint Filing Agreement

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SIGNATURES

After reasonable inquiry and to the best of our knowledge and belief, each of the undersigned hereby certifies that the information set forth in this statement is true, complete and correct.

Date: September 8, 2011

IGOR V. ZYUZIN

/s/ Igor V. Zyuzin

CALRIDGE LIMITED

By: /s/ Stella Raouna
Name: Stella Raouna
Title: Director

BELLASIS HOLDINGS LIMITED

By: /s/ Stella Raouna
Name: Stella Raouna
Title: Director

ARMOLINK LIMITED

By: /s/ Soterakis Koupepides
Name: Soterakis Koupepides
Title: Director

METHOL OOO

By: /s/ Tatyana Ifutina
Name: Tatyana Ifutina
Title: General Director

ACTIONDEAL LIMITED

By: /s/ Menikos Yiannakou
Name: Menikos Yiannakou
Title: Director

CYBERWOOD LIMITED

By: /s/ Menikos Yiannakou
Name: Menikos Yiannakou
Title: Director

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EXHIBIT INDEX

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1	Joint Filing Agreement